



Dear Prospective Patient:

At the Shepherd Spine and Pain Institute, we specialize in the evaluation, diagnosis and application of non-interventional and interventional treatments for pain management and related conditions. By using a multidisciplinary approach and latest medical technologies, we provide our patients with the best opportunity to maintain a healthy lifestyle.

We believe the patient should take an active role in his/her treatment plan. We encourage your involvement in the medical decision-making process and invite questions regarding treatment options. Your first visit with us is a time to meet the provider and establish a treatment plan. Please understand, there will be **no pain medications prescribed nor refilled during your first consultation. There will also be no procedures performed during this visit.** If you need a medication refill, please follow up with your primary care physician or referring provider.

For us to provide you with the most comprehensive care possible, it is essential we learn all we can about you and your current spine and/or pain condition(s). For your benefit, there is a medical release form to complete and return, or you may give directly to your primary care physician, pain specialist, or other medical provider who has recently (last two to three years) provided care for your pain issue.

**If you have an Emory physician**, please have your records sent directly to Shepherd Spine and Pain Institute. It is your responsibility to ensure all pertinent medical records have been sent.

On the day of your new patient evaluation, it is important to arrive no later than 30 minutes prior to your designated appointment time to allow for registration. You are excused one cancellation or rescheduled appointment for the initial new patient visit.

Thank you in advance for your cooperation and we look forward to providing you with individualized, comprehensive, state-of-the-art care you deserve.

Sincerely,  
New Patient Coordinator  
Shepherd Spine and Pain Institute  
Phone: (404) 603-4203  
Fax: (404) 603-4418  
[painreferrals@shepherd.org](mailto:painreferrals@shepherd.org)  
[www.shepherdpaininstitute.org](http://www.shepherdpaininstitute.org)



## Patient Questionnaire

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Initial: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

1. What is the purpose of your visit with the Shepherd Spine and Pain Institute? Please check all that apply:

- |   |   |
|---|---|
| <input type="checkbox"/> Current pain provider does not provide a specific medical treatment. | <input type="checkbox"/> Ketamine Infusions     |
| <input type="checkbox"/> Second Opinion   | <input type="checkbox"/> Intrathecal Pump       |
| <input type="checkbox"/> Want to change pain providers  | <input type="checkbox"/> Spinal Cord Stimulator |
| <input type="checkbox"/> Prolotherapy   | <input type="checkbox"/> Other: _____           |

2. Are you diagnosed with any of the following conditions? Please check all that apply:

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> Catastrophic Injury  | <input type="checkbox"/> Failed Back  |
| <input type="checkbox"/> Central Nerve Pain   | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Chronic Regional Pain Syndrome (CRPS)/Reflex Sympathetic Dystrophy (RSD) |                                       |

3. Do you currently have a pain provider? If yes, what is the name and contact number of the provider?

- No
- Yes, Provider Name: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

4. Have you previously been treated by a pain provider? If yes, please explain why you are no longer under the care of the pain provider?

- No
- Yes, Provider Name: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_



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5. Have you been diagnosed with a psychological disorder? If yes, what is the diagnosis?

- No       Yes:

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6. If yes to question 5, please provide the psychiatrist and/or psychologist name(s) and contact number(s).

Psychiatrist Name: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Psychologist Name: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

7. Do you have an intrathecal pump for pain control?

- No  
 Yes, Brand: \_\_\_\_\_

8. Do you have an open litigation or lawyer pertaining to your pain issue?

- No  
 Yes, Explain: \_\_\_\_\_

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### New Patient Demographics

Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Initial: \_\_\_\_\_ DOB: \_\_\_\_\_ SS #: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Language: \_\_\_\_\_

Religion: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Email: \_\_\_\_\_

Ok to use email for communication?  Yes  No

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

#### Insurance Information

Primary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

Group #: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

SS # of Policy Holder: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

Group #: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

SS # of Policy Holder: \_\_\_\_\_



**Shepherd Center**  
SPINE AND PAIN INSTITUTE

- Please provide a copy of the front and back of your insurance card(s).
- Please complete forms and return by mail, fax, or email:

Shepherd Spine and Pain Institute

Phone: 404-603-4203

Attn: New Patient Coordinator

Fax: 404-603-4418

2020 Peachtree Road, NW

Email: [painreferrals@shepherd.org](mailto:painreferrals@shepherd.org)

Atlanta, Georgia 30309

- For questions, please contact our New Patient Coordinator by phone 404-603-4203 or email [painreferrals@shepherd.org](mailto:painreferrals@shepherd.org)